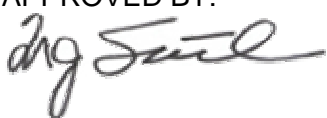




DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

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APPROVED BY:  Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 2

PURPOSE

- 1.1 To provide charting/documentation guidelines related to the delivery of Specialty Mental Health Services under the Rehabilitation Option utilized by the State of California for Medi-Cal services.
- 1.2 To provide charting/documentation guidelines for non-Medi-Cal/Medicare programs.

POLICY

- 2.1 The Department of Mental Health (DMH) has adopted the Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services as its official standard describing services, minimal staffing requirements, and lockouts for Medi-Cal services.
 - 2.1.1 In addition to minimum charting requirements, the full array of services that may be delivered as Specialty Mental Health Services under Code of California Regulation (CCR) Title 9, Chapter 11 are described in detail in the manual.

DEFINITION

3.1 MEDICAL NECESSITY GUIDELINES

- 3.1.1 For a service to be considered medically necessary and reasonable it must meet all of the following criteria:
 - ♦ a client must be diagnosed with an included diagnosis;
 - ♦ must have impairments that are a result of the mental disorder(s);
 - ♦ must receive interventions designed to address the condition and significantly diminish the impairment or prevent significant deterioration in an important area of life functioning; and
 - ♦ the condition would not be responsive to physical health care based treatment.
- 3.1.2 In addition to the criteria listed above, **persons under 21 years of age** can meet medical necessity criteria when all of the following exist:
 - ♦ has an included diagnosis;
 - ♦ has a condition that would not be responsive to physical care based treatment;
 - and



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- ♦ the requirements of Title 22, Section 51340(e)(3) are met. In the case of targeted case management, in addition to the above, medical necessity is met under Section 1830.205 and Section 51340(f).

3.1.3 As CalWORKs and GAIN programs have very different treatment objectives than other payor sources, these criteria may not apply to reimbursement in these programs.

PROCEDURE

4.1 INITIAL ASSESSMENT

- 4.1.1 Initial clinical evaluations must be completed within 60 days of intake for a new admission {no open episodes}, or within 30 days when the client is being opened to a new service, but has other open episodes.
- 4.1.2 The initial clinical assessment contains:
- ♦ presenting problem(s) and relevant conditions affecting the client's physical and mental health status, i.e., living situation, daily activities, social support;
 - ♦ presenting problems which indicate a functional deficit;
 - ♦ clear indication as to why the client is seeking treatment at this time; and
 - ♦ a behavioral health history including:
 - previous treatment dates;
 - previous and present mental health providers;
 - previous therapeutic interventions and responses;
 - relevant family information;
 - relevant lab reports, consultations, and sources of clinical data; and
 - past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and/or over-the-counter drugs.
 - ♦ **for children and adolescents**, pre-natal and peri-natal events and complete developmental history;
 - ♦ a brief psychosocial history;
 - ♦ a relevant mental status examination with narrative about symptoms;
 - ♦ a medical summary is present and contains a brief relevant medical history;
 - ♦ history of psychiatric medications that have been prescribed, including dosages of each medication;
 - ♦ client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities are clearly documented;
 - ♦ client's strengths in achieving service plan goals;



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- ♦ special status situations that present a risk to the client are documented and updated when changes occur;
- ♦ adequate information to assess the client's needs in order to formulate a treatment plan;
- ♦ a five axis DSM (current edition) diagnosis, which meets the requirements in CCR, Title 9, Chap 11, Section 1830.205(b)(1)(A-R); and
- ♦ housing, employment and benefit status.

4.1.3 Residential Programs (Crisis, Transitional, and Long Term)

4.1.3.1 The written assessment shall be completed upon admission and include:

- ♦ health and psychiatric histories;
- ♦ psychosocial skills;
- ♦ social support skills;
- ♦ current psychological, educational, vocational and other functional limitations;
- ♦ medical needs, as reported; and
- ♦ meal planning, shopping, and budgeting skills.

4.1.4 Socialization and Vocational Programs

4.1.4.1 A written assessment shall be completed within 60 days (if there are no other services being provided to the client); or within 30 days (if this is an added service). The assessment should include:

- ♦ information regarding the client's social support system;
- ♦ current levels of social, educational, and vocational functioning;
- ♦ survival skills;
- ♦ medical needs; and
- ♦ community resources.

4.2 ANNUAL ASSESSMENT UPDATE

4.2.1 The Annual Assessment Update (formally the Community Functioning Evaluation) shall be completed annually for individuals receiving ongoing services including Medication Support and Targeted Case Management. This document will be used to verify medical necessity on an annual basis.



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4.2.2 The Annual Assessment Update should include:

- ♦ a description of the progress the client has made toward meeting goals since the last assessment;
- ♦ current symptoms/problems;
- ♦ a description of any co-occurring (substance abuse) issues that influence the symptoms, impairment, and treatment;
- ♦ a description of any cultural factors that influence the symptoms, impairment, and treatment;
- ♦ a current assessment of the client:
 - ♦ living arrangements;
 - ♦ social support systems;
 - ♦ financial benefits;
 - ♦ daily activities/vocational/educational activities;
 - ♦ physical health;
 - ♦ hospitalizations and use of Psychiatric Mobile Response and Crisis Stabilization; and
 - ♦ use of the legal system
- ♦ a description of how the client meets Medical Necessity; and
- ♦ the signature of a licensed practitioner and service provider, if appropriate.

4.3 CLIENT CARE/COORDINATION PLAN

- 4.3.1 A Client Care Plan is required for all services, including Medication Support and Targeted Case Management.
- 4.3.2 The Client Care Plan must clearly address the problems identified in the initial assessment or Annual Assessment Update.
- 4.3.3 The Client Care Plan shall be completed by the end of the Intake Period (2 months) or within a month of any additional planned services.
- 4.3.4 For **Crisis Residential** services, the Client Care Plan shall be completed within 72 hours of admission into the program.
- 4.3.5 The Client Care Plan shall contain (Medi-Cal/Short-Doyle):
 - ♦ a statement of Long-Term goals (treatment outcome) in the client's words;
 - ♦ presenting problems/symptoms;
 - ♦ a description of functional impairment;
 - ♦ identified barriers to meeting goals;



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- ♦ linguistic/cultural, co-occurring, and/or health factors that may impact goal achievement (if applicable);
- ♦ a description of client strengths;
- ♦ specific, measurable, achievable, realistic, time-bound objectives;
- ♦ proposed clinical/case management interventions;
- ♦ identified type(s) and frequency of services; and
- ♦ outcomes when goals have been achieved or, at a minimum, every time the client plan has a scheduled review.

4.3.6 **The Client Care Plan shall be updated as clinically appropriate, but at a minimum, shall be reviewed and:**

- ♦ rewritten annually (prior to the month of intake) for Medication Support and Targeted Case Management;
- ♦ every 6 months **and** rewritten annually according to month of intake for Mental Health Services, Socialization, and Vocational services;
- ♦ weekly in Crisis Residential programs;
- ♦ every 30 days in Transitional Residential programs, updated every 6 months **and** rewritten annually;
- ♦ every 60 days in Long Term Residential programs updated every 6 months **and** rewritten annually;
- ♦ **and** updated prior to the expiration of authorized services which may never exceed 3 months for Intensive Day Treatment Intensive programs;
- ♦ **and** updated prior to the expiration of authorized services which may never exceed every 6 months for Day Rehabilitation.

4.3.7 For **Therapeutic Behavioral Services (TBS)**, the Client Care Plan must identify:

- ♦ specific targeted behaviors or symptoms that are jeopardizing the current placement (not school placement) or are presenting a barrier to transition;
- ♦ specific interventions to resolve behaviors or symptoms;
- ♦ specific outcome measures that can be used to demonstrate that the frequency of target behaviors has declined and has been replaced by adaptive behaviors;
- ♦ a transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed, or when the need to continue TBS appears to have reached a plateau in benefit effectiveness; and
- ♦ the manner of assisting parents/caregivers with skills and strategies to provide continuity of care when the services are discontinued.



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4.3.8 The Client Care section of the Plan shall contain the dated signatures of:

- ♦ the client;
- ♦ the Service Delivery Staff/Care Coordinator;
- ♦ a Licensed Practitioner of the Healing Arts;
- ♦ a Physician for Medicare/Private Insurance clients and clients receiving medications; and
- ♦ a Family Member/Conservator (if appropriate).

4.3.9 A copy of the Client Care section of the Plan shall be given to the client/family/caregiver.

4.3.10 The Client Care section of the Plan shall be completed by the end of the Intake Period.

4.3.10.1 After the Intake Period, the Client Care section of the Plan shall be updated:

- ♦ within one month of the first contact for an added service; and
- ♦ annually according to the month of intake schedule.

4.3.11 The Coordination section of the Plan shall include:

- ♦ all services from all agencies involved in the individual's care, including TBS;
- ♦ periods of authorized services - start and end dates;
- ♦ provider Identification - provider number;
- ♦ documentation of face-to-face contact with the individual or documentation of why not in cases when individual refuses to meet;
- ♦ the Coordinator's verification that the individual meets Medical Necessity; and
- ♦ the signature of a licensed practitioner and single fixed point of responsibility.

4.3.12 A progress note shall be entered when the Coordinator has the annual face-to-face contact verifying Medical Necessity and indicating completion of the coordination section of the Client Care/Coordination Plan.



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4.4 PROGRESS NOTES

4.4.1 Psychopharmacology/Medication Support General Guidelines

- 4.4.1.1 If the client receives psychotropic medications prescribed by a physician in the program, there shall be documentation in the chart that the client has been informed of the right to accept or refuse such medication(s). (*Title 9, 851*)
- 4.4.1.2 The information received by the client from the prescribing physician (and documented) shall include, but need not be limited to: (*Title 9, 851*)
- ♦ nature of the client's mental condition;
 - ♦ the reason(s) for taking the medication(s);
 - ♦ reasonable alternative treatments, if available;
 - ♦ type, range of frequency and amount, method, and duration of taking medication(s); and
 - ♦ probable side effects which commonly occur and any particular side effects which are likely to occur if medication is taken beyond three (3) months.
- 4.4.1.3 An Outpatient Medication Review form, signed by the client, indicating that the above information has been discussed with the client shall be placed in the client record or the above information shall be noted in a progress note.
- 4.4.1.4 For medications prescribed in DMH directly-operated programs, physicians shall complete the Outpatient Medication Review form and record in the progress note that the medication review was completed.
- 4.4.1.5 A description of what was attempted and/or accomplished at the time the service was provided shall be included in the progress notes.
- 4.4.1.6 If medication is prescribed/dispensed/administered by the clinic, in addition to the requirements noted in 4.4.1.2, the chart note shall contain the following:
- ♦ the name of the medication;
 - ♦ the dosage of the medication;
 - ♦ quantity of medications;
 - ♦ frequency of administration; and
 - ♦ route of administration.



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- 4.4.1.7 There shall be documentation at each visit indicating the client has been questioned about:
- ♦ side effects;
 - ♦ response to medication, both positive and adverse; and
 - ♦ client's compliance with the medication regime.
- 4.4.1.8 Medication orders must be signed by an appropriately licensed person.
- 4.4.1.9 When medication support services are provided by non-physician staff (within scope of practice) in addition to the requirements noted in 4.4.1.2, the minimum documentation requirements include:
- ♦ Description of the client's response to the medication, side effects, and compliance with medication.
- 4.4.1.10 If outside physicians prescribe psychotropic medications, complete information about such medications shall be documented in the chart.
- 4.4.1.11 Reasons for changes in medication and/or dosage shall be clearly documented by the psychiatrist.
- 4.4.1.12 **For Children Only:** Clients for whom medications are necessary in the evaluation and treatment of their psychiatric disorder shall be instructed to obtain a physical examination. If the client or family/caregiver refuses, this refusal shall be noted in the chart.

4.5 MENTAL HEALTH SERVICES

- 4.5.1 Each Client encounter must be charted, including clinical decisions and interventions made.
- 4.5.2 Collateral sessions must focus on the treatment of the identified client.
- 4.5.3 Case Presentations, at a minimum, shall contain the date of the presentation, the reason for the presentation, issues discussed, and services suggested.
- 4.5.4 When two staff deliver the **same** service to two or more clients, select a group Procedure Code that represents the service. One staff must be identified as the Rendering Provider for each client for whom a service is to be claimed. Each client's Rendering Provider must write the note for that client. The note must document the entire service, including the



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intervention contribution of each staff present. The note should begin with language similar to "Co-led service with ...(the name of staff and his/her title)." Each staff person's total time, including the Rendering Provider, is the only time that needs to be documented.

4.6 TARGETED CASE MANAGEMENT

4.6.1 There must be a note for each service related to Targeted Case Management.

4.7 DAY TREATMENT INTENSIVE PROGRAMS

4.7.1 Day Treatment Intensive Programs require daily notes describing services, as well as weekly notes containing a brief narrative description regarding what was attempted and/or accomplished by the client and the service staff toward meeting goals.

4.8 DAY REHABILITATION PROGRAMS

4.8.1 Day Rehabilitation Programs require a weekly summary containing a brief narrative describing what was attempted and/or accomplished by the client and the service staff toward meeting goals.

4.9 SOCIALIZATION AND VOCATIONAL PROGRAMS

4.9.1 Socialization and Vocational Programs require a weekly note containing:

- ♦ an indication of the activities in which the client participated;
- ♦ a brief narrative describing what was attempted and/or accomplished by the client and the service staff toward meeting goals;
- ♦ the current functional level; and
- ♦ the current functional impairment.

4.10 THERAPEUTIC BEHAVIORAL SERVICES

4.10.1 Therapeutic Behavioral Services (TBS) require a daily progress note, written by the TBS Specialist, that includes specific interventions and results of said interventions.

4.10.2 The progress note shall include interagency case conferencing (including the placing agency, therapist, and a clinical supervisor) regarding discussion of the recommendation to provide TBS.



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4.10.3 There shall be a monthly progress note, written by the clinical team, that documents progress toward objectives.

4.11 RESIDENTIAL PROGRAMS

4.11.1 For **Crisis Residential** there shall be a daily note for each day the client is in the program.

- ♦ There shall be a note whenever a scheduled session takes place with the client.
- ♦ There shall be a note indicating the activities in which the client participated.

4.11.2 For **Transitional Residential** there shall be at least a weekly note while the client is in the program.

- ♦ There shall be a note whenever a scheduled session takes place with the client.
- ♦ There shall be a note indicating the activities in which the client participated.

4.11.3 For **Long Term Residential** there shall be at least a weekly note while the client is in the program.

- ♦ There shall be a note whenever a scheduled session takes place with the client.
- ♦ There shall be a note indicating the activities in which the client participated.

4.11.4 Progress notes shall address:

- ♦ client's behaviors and staff intervention;
- ♦ progress towards objectives or documentation of lack of progress;
- ♦ involvement of family members, if appropriate; and
- ♦ contact with other programs/agencies/treatment personnel involved with the client.

4.11.5 There shall be notes present for all staff involved with the client's treatment.

4.12 DISCHARGE SUMMARY (FOR CLOSED CASES)

4.12.1 If the case has been inactive for 90 days, a review must be documented in the chart, which includes a recommendation to close or to leave open. (County)

4.12.2 If the case has been inactive for 120 days or more, the chart shall either be completed and closed or there shall be documentation stating why the chart is not closed. (County)



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4.12.3 There shall be a discharge summary or note which includes: (County)

- ♦ date of discharge;
- ♦ a recapitulation of the course of treatment;
- ♦ aftercare referrals and recommendations with proper referral-out codes;
- ♦ a description of the client's condition on discharge;
- ♦ medication at discharge; and
- ♦ the client's immediate disposition at discharge.

4.12.4 The discharge section of the client face sheet shall be completed and information entered into the Integrated System.

4.13 COMMUNITY OUTREACH SERVICES

4.13.1 Documentation for Community Outreach Services shall be in accordance with Community Outreach Manual and filed in a secure location.

4.14 PSYCHOLOGICAL TESTING (PLACE HOLDER)

4.14.1 Only the final report shall be placed in the clinical record. Raw data must be securely maintained by the clinic.

AUTHORITY

California Code of Regulations, Title IX, Chapter 11, Medi-Cal Specialty Mental Health Services
Los Angeles County Community Outreach Manual
CalWORKs or GROW Manuals, Other Programs

REFERENCES

DMH Policy No. 200.1, Service Delivery Definition Policy

REVIEW DATE

This policy shall be reviewed on or before September 2006.